

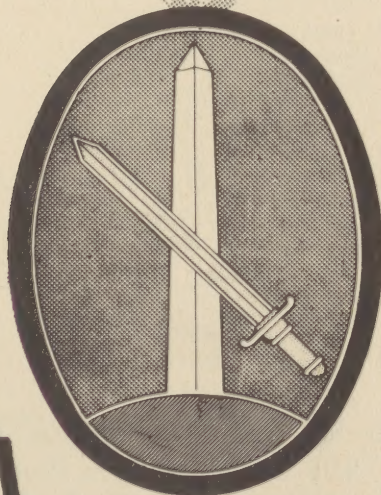
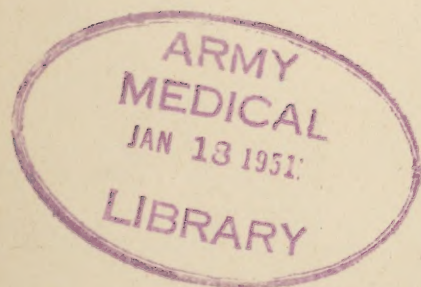
2
116 m
VOLUME 3
REPORT NO. 12

713
(DOCUMENT SECTION)

RESTRICTED

MONTHLY HEALTH REPORT

Military District of Washington



RESTRICTED

December 1950



THIS DOCUMENT CONTAINS INFORMATION
AFFECTING THE NATIONAL DEFENSE OF
THE UNITED STATES WITHIN THE MEANING
OF THE ESPIONAGE LAWS, TITLE 18, U.S.C.,
SECTIONS 793 AND 794. THE TRANSMISSION
OR THE REVELATION OF ITS CONTENTS IN
ANY MANNER TO AN UNAUTHORIZED PER-
SON IS PROHIBITED BY LAW.

HEADQUARTERS, MILITARY DISTRICT OF WASHINGTON
Room 1543, Building T-7, Gravelly Point
Washington 25, D. C.



INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as a basis for requisitioning supplies or equipment.

Contributions, as well as suggested topics for discussion, are solicited from Army Medical Service personnel in the field.

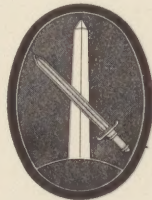


Robert E. Bitner

ROBERT E. BITNER
Colonel, MC
Surgeon

CONTENTS

ADMINISTRATIVE SERVICE		PAGE
Principles of Organization		3
Your Personal Checklist.		4
Volunteer Blood Program		5
The Medical Soldier as a Morale Booster		5
First Aid Training		6
Check List for Living		12
Military Assistance.		11
Table -- Hospital Mess Administration.		20
Table -- Outpatient Service		20
CIVILIAN EMPLOYEES' HEALTH SERVICE PROGRAM		
The Nurse in the Civilian Employee Health Service.		21
DENTAL SERVICE		
Table -- Dental Service.		20
PREVENTIVE MEDICINE		
General Comment.		13
Communicable Disease		13
Table -- General Data		14
Table -- Admissions, Specified Disease		14
Venereal Disease		15
Table -- New Venereal Disease Cases.		15
Chart -- Admission Rates of Common Respiratory Disease and Injury.		16
Chart -- Venereal Disease Admission Rates by Month		16
Table -- Consolidated Venereal Disease Statistical Report.		19
Table -- Venereal Disease Rates for U. S.		18
Chart -- Venereal Disease Total Rates		18
Chart -- Venereal Disease White Rates.		17
Chart -- Venereal Disease Negro Rates.		17
PROFESSIONAL SERVICES		
Disseminated Pulmonary Calcification		1
VETERINARY SERVICE		
National Security and the Veterinarian		7
Good Neighbor Policy		10
Table -- Veterinary Service.		20



DUFRENNE

1893 — 1950

Death, as it must come to all men, came suddenly on 13 December 1950 to Martin F. DuFrenne, Colonel, MC, USA, War-time Surgeon MDW, Commanding Officer of the US Army Hospital, Fort Belvoir.

Colonel DuFrenne, a native of Wisconsin, received his medical degree from Marquette University in 1916. He entered the military service in January 1918 as a 1st Lieutenant, M.C. After service during World War I, he elected to remain in the Military service and was commissioned in the Regular Army. Colonel DuFrenne is the holder of the Legion of Merit and Commendation Ribbon. He is a graduate of the Command and General Staff College and the Medical Field Service School.

The Legion of Merit was bestowed upon Colonel Martin F. DuFrenne for having served with marked distinction as Surgeon, Military District of Washington and as Commanding Officer, Station Hospital, Fort Myer, Virginia, from August 31, 1942 to June 9, 1945.

Throughout his entire career in the medical service, Dr. DuFrenne, although often working under the stress of heavy responsibilities, at all times exercised unfailing good cheer, a sympathetic attitude toward the sick and wounded and displayed outstanding professional skill.

By his splendid example, Colonel DuFrenne inspired those who worked under him. His devotion to duty, and the service he rendered are in keeping with the highest traditions of the United States Army.

"Let Them Rest From Their Labors, For Their
Works Follow Them" (Epistle, Apoc. 14)

PROFESSIONAL SERVICE

DISSEMINATED PULMONARY CALCIFICATION

By

Bela Gondos, M.D., Roentgenologist
and

James F. DeLoach, Captain, MC
US Army Dispensary, The Pentagon

Until recently pulmonary calcification and calcification of the tracheo-bronchial lymph nodes were considered pathognomonic for tuberculosis. Recent observations showed however, that such calcification occur in an unexpectedly high percentage of cases with negative tuberculin tests. The discrepancy became more apparent in the eastern central states of the United States, where a relatively great number of such calcifications were discovered. The observation that histoplasmosis (caused by fungus *Histoplasma capsulatum*) occurs mostly in this area, directed attention towards the possible relationship between pulmonary calcification and histoplasmosis.

The extensive investigations connected with chest x-ray surveys as well as with tuberculin and histoplasmin tests, carried out under the auspices of the National Tuberculosis Association and the United States Public Health Service, showed that there is a much higher percentage of histoplasmosis sensitivity in the states of the east central area of the United States than in the remainder of the country. Among 16,320 student nurses of different metropolitan areas Kansas City, Mo. and Columbus, Ohio showed a percentage above 60, New Orleans and Baltimore about 25, Denver, Minneapolis and San Francisco had a percentage below 10. The frequency of tuberculin sensitivity in the different cities varied between 22.8 percent and 7.9 percent. The significance of the geography in the incidence of histoplasmin sensitivity was emphasized by Palmer, who found that with increased distance from the eastern central states the number of reactors to histoplasmin are increasing. A comparison of these figures with those of the pulmonary calcifications showed grossly a parallelism of both. No such parallelism exists in the case of tuberculosis. Kansas City, Mo. and Philadelphia have approximately the same frequency of tuberculin sensitivity, but the number of calcifications was four times greater in Kansas City than in Philadelphia. It was also shown that calcifications among reactors to histoplasmin alone was three times as high as among reactors to tuberculin alone.

More striking is the relationship between pulmonary calcification and histoplasmin sensitivity in cases of disseminated calcifications. Many of such cases were considered in the past as healed military tuberculosis. Furcolow gives account of 174 disseminated pulmonary calcification. Ninety-eight percent of these individuals showed positive histoplasmin test and 13 percent reacted in tuberculin. A comparison of the percentage figures indicates that disseminated pulmonary calcifications is more frequently associated with histoplasmin sensitivity than the other types of calcifications.

As a result of the investigations outlined above it became apparent that tuberculosis is not the only source of calcification in the lung and mediastinum. The previous concept should be revised. We must assume that histoplasmosis or an immunologically related disease can also produce such changes. In a recent article Furcolow presents the proof of this possibility. He describes two cases of histoplasmosis, proved by the recovery of the fungus, in which the development of disseminated pulmonary calcification from exudative infiltration is followed and illustrated by x-ray films.

In the Army Dispensary, Pentagon, we have seen nine cases of disseminated pulmonary calcification during a relatively brief period of time (August 3 1950-November 8, 1950). The number of cases is few as compared with those reported elsewhere. It may not be unworthy however, to give a preliminary report of our limited experience considering that disseminated pulmonary calcification is very uncommon in the area of the District of Columbia. It may also be of interest because of the different type of material and the importance of the evaluation of the individuals involved as to their acceptability for military service. All of our cases were incidental findings discovered in routine chest x-ray examinations. These individuals were in complete health and only one had a history which might be related to the pulmonary findings. This patient gave a history of "pneumonia" in 1939 and had hospitalization while in the service in 1945 as well as in 1949 for "severe cold". No x-ray films are available from the past and the significance of this history remains open. Another patient 23 years of age had a history of so-called spontaneous pneumothorax in September 1950, with complete recovery. Incidence of spontaneous pneumothorax used to occur in healthy young adults mostly as the result of superficial blebs. It is considered a clinical entity and not related to tuberculosis. It seems to be very questionable whether this incidence has any relationship to the pathology represented by the pulmonary calcification. In two of the cases calcification was known

PROFESSIONAL SERVICE

by the patient and the course was followed from 1941 and 1944 respectively, showing no evidence of any activity. Five of the nine cases were investigated by tuberculin and histoplasmin tests. All of them reacted to histoplasmin, but only one to tuberculin. These findings are corresponding with those of the literature. Medical clearance was given by this Installation in the cases where the question of acceptability for military service came up. This standpoint was based on the history, on the clinical and x-ray findings and on the conclusions drawn from the literature.

In conclusion it is reasonable to assume that most of the cases of disseminated pulmonary and mediastinal calcifications are the result of histoplasmosis infection. In the majority of the cases it apparently produces a disease having a sub-clinical course. Tuberculosis must have a less significant role. The incidental findings of calcification reported in the literature and seen by us were encountered in individuals of complete health and it is our impression that these changes should be considered as closed pathology.

Bibliography: Furcolow, M.L., Further Observations on Histoplasmosis. Public Health Reports 1950, Vol. 65 Pp. 965-994. Tuberculin Negative, Histoplasmin Positive, Disseminated Pulmonary Calcification. Post Graduate Medicine, 1950 Vol. 8 Pp. 15-20.

Goddard, G. C., Edwards, L. B. and Palmer C. E., Relationship of Pulmonary Calcification with Sensitivity to Tuberculin and to Histoplasmin. Public Health Reports, July 1949, Vol. 64, Pp. 820-844.

Zwerling, H. B. and Palmer, E. C., Pulmonary Calcifications: Roentgenographic Observations in Relation to Histoplasmin and Tuberculin Reactions. Radiology, 1946, Vol. 47 Pp. 59-63.

Doub, H. P., Miliary Calcification of the Lung. Etiologic Aspect. Radiology, 1948, Vol. 51 Pp. 480-490.

Kneidel, J. H. and Segall, H., Acute Disseminated Histoplasmosis in Children. Report on Three Cases. Pediatrics, 1949, Vol. 4 Pp. 596-603.

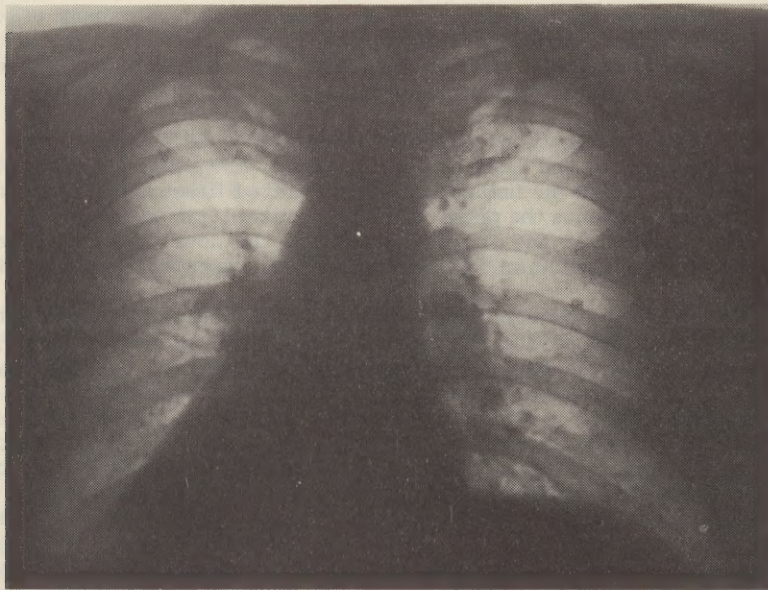


Figure 1: H.C.H. Multiple calcifications in both lung fields and in the right hilus. No changes demonstrable since 1942. The patient reacted to the tuberculin (++) and had a violent reaction to histoplasmin.

PROFESSIONAL SERVICE

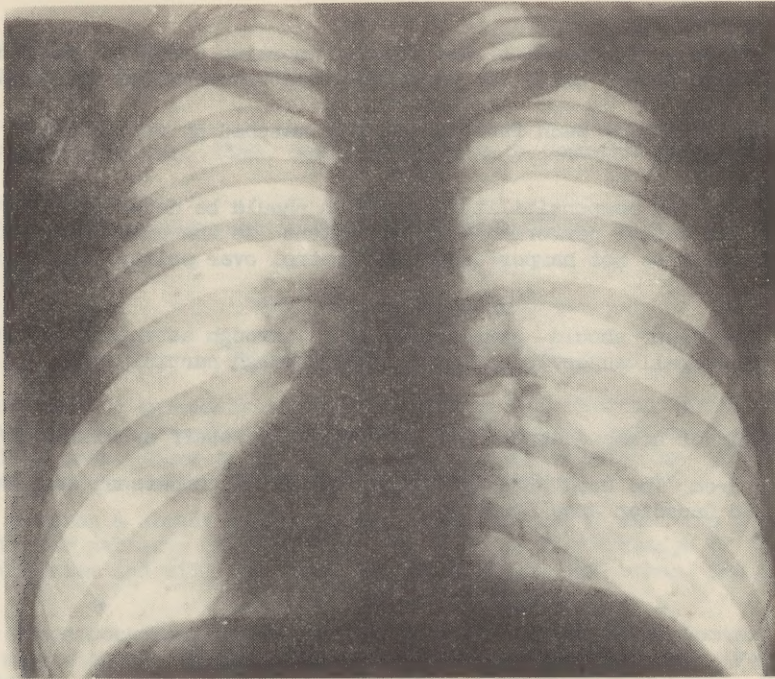


Figure 2: A. M. Disseminated pulmonary calcification. No calcification in the mediastinal nodes. Tuberculin test: Negative. Histoplasmin test: Strongly positive. The patient is in complete health.

ADMINISTRATIVE SERVICE

PRINCIPLES OF ORGANIZATION

The following are twelve basic principles:

1. Every necessary function of an organization must be assigned to a section of that organization.
2. The responsibilities assigned to every unit of the organization must be specific, understandable and understood.
3. No particular function should be assigned to more than one independent unit of the organization since overlapping responsibility may cause duplications, conflict, confusion, and delay.
4. Consistent methods of organizational structure should be applied at each level of organization.
5. The organization must never be permitted to become so elaborate that its work is hindered by that elaborateness. If an organization is to be completely effective it is essential that it be accurately documented, with a statement of functions and an organization chart, and those documents distributed to all members of the organization and to all those who are in frequent contact with any part of it; thus without interfering with essential flexibility.
6. Each member of the organization from top to bottom must know to whom he reports, and who reports to him.
7. No member of the organization should report to more than one supervisor.

ADMINISTRATIVE SERVICE

8. The number of independent individuals reporting directly to a supervisor should not exceed the number (four to seven) which can be effectively co-ordinated and directed.

9. Responsibility for each function must be matched by the necessary authority to ensure performance of that function.

10. Authority and responsibility for action should be decentralized to the units and individuals responsible for actual performance of operations to the greatest possible extent, so long as such decentralization does not hamper essential control over policy and standardization of procedures.

11. The supervisor should exercise control through attention to policy and matters of special importance; by overall supervision rather than through participation in the routine actions of his subordinates.

12. Channels of command should not be violated by staff specialists.

(The above article is from "The Good Officer" by Lt. Col. F. E. Anderson, Army Headquarters, Ottawa, Vol. 4, No. 2, May 1950 Canadian Army Journal).

* * * * *

YOUR PERSONAL CHECKLIST

PREPARING THE RECORD

Make a checklist of all your valuables and belongings. File it in a safe place.

PREPARING A WILL

Consult your Legal Assistance Officer or private attorney. If desired The Adjutant General, Washington 25, D. C., will hold your will in a safe place.

POWER OF ATTORNEY

See your Legal Assistance Officer or private attorney. Legal counsel is vitally important in making this commitment.

INSURANCE

See your Insurance or Legal Assistance Officer. In matters pertaining to National Service Life Insurance (NSLI), the nearest office of the Veterans Administration can also provide counsel. NSLI offers from \$1000 to \$10,000 insurance coverage, in multiples of \$500, with premiums payable by allotment from service pay. Insurance holdings--both NSLI and commercial--should be recorded on checklist of belongings.

ALLOTMENTS

Legal Assistance, Finance or Commanding Officer can provide information.

FINANCIAL ASSISTANCE

Legal Assistance, Commanding Officer or Red Cross Field Director can provide counsel. Dependents may apply to American Red Cross local chapter or Army Emergency Relief.

TRANSPORTATION OF DEPENDENTS AND HOUSEHOLD GOODS

Dependents should be notified of rights, including transportation for families of officers and enlisted personnel of the top three grades (or personnel in grade E-4 with seven or more years of service) granted upon permanent change of station. Rights also applicable to dependents of all enlisted personnel who become prisoners of war, wounded, besieged or beleaguered. For details, see Commanding Officer or Transportation Officer.

DEPENDENTS HOUSING

Commanding Officer or American Red Cross Field Director can provide information.

ADMINISTRATIVE SERVICE

LOSS OR DAMAGE TO PERSONAL PROPERTY

Consult Claims or Commanding Officer.

VETERANS' BENEFITS

Veterans Administration, TI&E, Legal Assistance or Commanding Officer can provide information.

(The above article is from Army Information Digest, November 1950)

* * * * *

VOLUNTEER BLOOD PROGRAM

By

Dwight Kuhns, Colonel, M.C.

Under articles of an agreement recently signed by Army Medical Center officials, the Walter Reed Army Hospital has become a member of the American Red Cross system of volunteer blood centers in the national capital area. Name of the former blood bank operated by the Hospital's Laboratory Service is to be known as the Walter Reed-Red Cross Blood Center.

This step insures a steady supply of blood and plasma to meet the greatly increased needs of the hospital both for patients and research. It provides for exchange of the donated blood with other members of the system and will add recruitment of donors and other Red Cross services to the local Center.

Hours for blood donations at the Walter Reed-Red Cross Blood Center will be from 9:30 to 12 Noon and from 2 to 4 o'clock, Tuesday, Wednesday, Thursday and Friday. For those who have only evening time, the Center will be open Tuesday evenings from 7 to 9 o'clock. Military personnel of the entire capital area are expected to be among the contributors, specific days and quotas having been set up accordingly.

Tuesday in Army Medical Center Day, 30 pints quota; Wednesday, Ft. Belvoir Day, 40 pints quota; Thursday, Andrews and Bolling Air Force Bases Day, 40 pints quota; and Friday, Ft. Myer, Arlington Farms and Ft. McNair Day, 30 pints quota.

First blood received through this new volunteer arrangement was on last Tuesday when friends and relatives of AMC duty and patient personnel came in for donations. Supervision of the blood center is to be conducted by a committee made up of Dr. Kenneth R. Nelson, Medical Director, Red Cross Washington Regional Blood Center, Dr. Worth Daniels, chairman of the Medical Advisory Committee (D.C. Med. Soc.), Washington Regional Blood Program and Major General Paul H. Streit, Commanding General, Army Medical Center. As Chief of the WRAH Laboratory Service, Col. Dwight M. Kuhns will represent the Commanding General on this committee whenever necessary. Dr. Nelson will act as consultant in matters connected with the Center and the hospital.

The agreement as worked out by the post authorities and the Red Cross is in accord with the standards set up by the American Medical Association. Such requirements meet the minimum qualifications for a blood center as established by the National Institute of Health.

(The above article is from "Service Stripe" 1 December 1950, Walter Reed Army Hospital)

* * * * *

THE MEDICAL SOLDIER AS A MORALE BOOSTER

By

OCTAVIO R. LUNA

In World War II I served as an aid-man, stretcher bearer, and ambulance driver with the 52d Medical Battalion. Although front-line medics receive adequate training for their duties, after a period of combat service they have a tendency to become calloused or hard-boiled and to use undue haste in giving aid treatment so they can pass the responsibility to someone else as quickly as possible, never giving a thought to the inner feelings and fears of the man they are aiding. I was shocked out of this condition when I heard a man sobbing as I applied a dressing to his wound. It was then that I realized how fortunate I was to be a medical soldier and that even though I was under fire, it was these men and not I who had to go out on patrol or attack when ordered to.

ADMINISTRATIVE SERVICE

The training manual emphasized that treatment should be given promptly and with dispatch, with no mention of "humanizing" this treatment. Needless to say, if ever a man needs a boost in morale, it is when he is lying on the ground wounded and helpless. This applies to all ages but especially to the younger ones on whom the Army must depend. Right then and there I made up my mind to do more than just apply bandages and splints. Even though I was scared myself, I put on a false front of courage and began to do the little extra things that mean so much at a time like that, such as giving a wounded man a lighted cigarette, telling him how much better off he was than the last man I had attended, and making him feel that he was luckier than the others.

I became so engrossed in morale building that strangely enough my own morale improved. Later, when I was given an ambulance and an assistant, I had even better opportunities to boost the morale of the wounded. Working from clearing station to evacuation hospital we devised a way to make every load we hauled believe that they were getting special attention. Each wounded man got cigarettes and a slug of wine from a rare bottle that we refilled out of a 5-gallon can we carried on our right fender. The label on that old bottle did wonders and some men arrived at the hospital a bit jolly. Every load got the same routine of how much luckier they were than the previous load. We also told them that they were in the hands of the 52d Medical Battalion, the best medical outfit in the Army, and they all agreed.

I do not know if these meager efforts had any over-all effect on the morale of these men, but I do know that we were repaid for our trouble by the grateful looks we received from everyone who got a little extra attention. I believe that, during training, front line medics should get at least one lecture on morale-boosting, covering points that are not mentioned in the manuals. I am proud that I was given the privilege to serve in the most respected branch of the Army, and this effort to "humanize" and better the lot of front line medics is directed to upholding that respect.

(The above article is from Medical Technicians Bulletin, November-December 1950, Vol. 1, No. 6)

* * * * *

FIRST AID TRAINING

This picture was taken after American National Red Cross Instructor Certificates were presented to the individuals by Colonel Robert E. Bitner, Surgeon, Military District of Washington.

All Medical Units within the Military District of Washington are conducting a course of instruction in First Aid to the Injured with the objective of qualifying all enlisted Medical Service Personnel in the basic course of First Aid to the Injured.



Left to Right: Captain John B. Selby; Captain Mary A. Pavlick; Captain Robert L. Massonneau; Colonel Robert E. Bitner, Surgeon, MDW; Major C. J. Addison; Captain Nicholas J. Conte; Captain Edwin R. Priest.

VETERINARY SERVICE

NATIONAL SECURITY AND THE VETERINARIAN

by

James A. McCallam

Brigadier General, Veterinary Corps, USA

In presenting this subject, the title of which is "National Security and the Veterinarian," an effort is made to chart a course the veterinary profession must follow in order to be prepared to aid in civil defense and military defense of the United States.

Is everyone having the degree of Doctor of Veterinary Medicine a veterinarian? Perhaps we who have that degree consider ourselves such. I grant the degree having been conferred upon us, we have the legal right to call ourselves veterinarians. But, are we? The mere conferment of the degree by a school of veterinary medicine does not per se mean you are a veterinarian. What have you done in any of the several fields of veterinary medicine for the betterment of your profession or for your local, state, and national veterinary medical associations that proves you worthy of the name? As a veterinarian and as a citizen are you contributing to the good of your community, your state, and your nation? Are you an individualist, or do you think and plan what is best for the profession as a whole and how the profession may contribute most to national welfare and security?

The history of veterinary medicine proves that the great majority of veterinarians do submerge any individualistic leanings for what is best for the profession and for the national welfare. The statement can be made unequivocally when applied to the contributions - yes, sacrifices - made by veterinarians as individuals and organized veterinary medicine during World War II. And I refer not only to those who were in military uniform.

The history of veterinary medicine in the United States is one of continued advancement and progress. This program has been such that veterinary medicine today bears no more relation to its original concept - when the primary field was principally equine practice and virtually confined to curative measures - than human medicine today bears to that practiced in the days of the Revolutionary War.

The rapid development of this country over a comparatively short span of time confronted many individuals and organizations with a challenge to join in the march of progress. Fortunately, among the veterinarians who trod the path prior to us there were a number of individuals with vision enough to forecast the broad scientific field in which veterinary medicine should develop, to recognize the challenge confronting veterinarians, and to see the necessity for a veterinary profession organized to meet successfully its obligation to the people and the nation.

As a result of their sagacity, veterinary medicine ventured into properly related fields which for many years some had not considered appropriate for members of our profession. Much of our progress and achievement can be ascribed to the leaven which they started; the opportunities they saw for veterinary medicine in related fields; and the importance of the veterinary profession to the economic life and stability of the United States. It would be superfluous for me to recite the advances made in organized veterinary preventive medicine and the control of diseases, in the specialties of bacteriology, pathology, virology, as well as in practice, and to reiterate the importance and position of the veterinarians in the field of public health, particularly food inspection and sanitation and in the study of those diseases transmissible from animal to man. Suffice it to say that the science of veterinary medicine today is recognized as essential not only to the economic life and stability of any country but to the health and well-being of the human race. As one example: some of the outstanding virologists in the world are veterinarians, and their advice is sought regarding various virus diseases affecting man, and not infrequently relative viral diseases transmissible from man to man. An example of disease control and a notable contribution to veterinary medicine to the economic life of the United States is the magnificent work of veterinarians of the Bureau of Animal Industry, United States Department of Agriculture, and those of the Republic of Mexico in the battle to control foot-and-mouth disease in the latter country, in spite of tremendous difficulty. One only needs meditate on the economic impact to this country had that epizootic spread north and the disease made its appearance among cattle in the United States.

Likewise, the accomplishments of the veterinary profession were of inestimable value both during and following World War II. The development of a chick embryo vaccine for rinderpest may be cited as a glowing example. However, veterinary medicine cannot and will not rest on past and

VETERINARY SERVICE

present achievements. The veterinary profession must be on the alert and keep step with changing conditions, not only in the United States but in the entire world, if we are to continue to contribute to the economic stability and to the general welfare and security of our free nation.

The world has grown smaller; so to speak. Until the past few years, the mainland of the United States has been more or less invulnerable to attack and invasion. The development of new weapons, and this term includes anything that could be used in war, has changed that concept. This country must be prepared for any catastrophe that might strike within its shores.

You have heard or have read statements by our leaders that we will not have a year or two in which to mobilize our defenses while the aggressor is being held in check. In this atomic age and with the development of new weapons it is essential that the civilian population of this country be organized and that plans be kept in readiness to be placed in effect immediately to cope with any foreseeable eventuality in connection with civil defense.

What is meant by civil defense? The term "civil defense" means all activities and measures designed to cope with an enemy attack which is successful in reaching a target within the United States, its territories, or possessions and which affects the civilian population. It pertains to activities and measures essential to meet immediate local emergency conditions. It must not be confused with military defense, which means all activities and measures designed to prevent the completion of any organized enemy military action directed at the United States, its territories, or its possessions.

For the past several years civil defense planning has been in progress. In 1948 the President appointed a committee headed by Mr. Hopley to study and report on the subject. The American Veterinary Medical Association was requested to appoint a representative on that committee. This is evidence that responsible public officials realize the serious consequences which could result in a national emergency through inefficient use of organized veterinary medicine. Since then a number of organizations and individuals have been engaged in civil defense planning.

In order to coordinate all planning, you are no doubt aware that the responsibility for civil defense planning recently was assigned to the National Security Resources Board by the President.

Under the directive from the President the National Security Resources Board has responsibility for the following:

1. Leadership in civil defense planning.
2. Development of a program.
3. Calling upon agencies of the Government for advice.
4. Consultation with States and local governments in developing the detailed planning for which they are most appropriately qualified.
5. Analysis as to how best to undertake the responsibility of civil defense planning.
6. Recommendations to the President concerning necessary actions, including any legislation requiring early attention.

The National Security Resources Board will no doubt coordinate planning within the Federal Government and be the channel for contact in civil defense planning between the Federal Government and the states, municipalities, and federal and trade organizations. Participating in planning generally would be the Atomic Energy Commission, Department of Defense, Federal Security Agency, and the Departments of Agriculture, Interior, Treasury and Justice.

Leadership in developing a program of wartime disaster relief has been delegated by the National Security Resources Board to the General Services Administration, currently expected to include planning for:

VETERINARY SERVICE

1. Medical supplies and services, including hospitalization, sanitation, and blood banks.
2. Decontamination and measures to minimize the effects of chemical, radiologic, and biologic or other unconventional attacks.
3. Fire protection and fire fighting.
4. Emergency measures for the regulation of transportation and communication facilities and services and the restoration of order, including conditions under which martial law would be declared and methods for invoking it.
5. Rescue and evacuation, including feeding, clothing, and sheltering.
6. Repair and restoration of water, gas, electric, and sewage systems, including antipollution measures.
7. Demolition.
8. Formation and use, only in the event of war, of warden or auxiliary services and mobile battalions, whose members will be prepared to implement appropriate phases of plans developed for wartime disaster relief.

The Department of Defense has been assigned planning for civilian participation in defense activities against armed forces, embracing air raid warning, civil air patrol, aircraft detection and identification, auxiliary defenses, camouflage, protective construction, and other physical measures of defense.

Internal security measures, including sabotage and espionage related to the civil defense program, will be coordinated by the National Security Council.

Although the Department of Defense will have certain responsibilities in connection with civil defense planning, it must be remembered, however, that the primary mission of the military forces will be to prevent or repel any organized military action which is physically directed at any part of the continental United States. It should be obvious that dispersion of this military effort by diversion to measures of furnishing total disaster relief to local areas must be prevented. To permit such diversion could only result in weakening our military effort directed against an enemy.

In any future war undoubtedly the civilian population will be directly affected and involved. It is, therefore, essential that organization and planning be effected so that communities will be prepared to aid one another in providing wartime disaster relief measures and to minimize the effects of unconventional attacks.

Although considerable study has been given to organization and planning for civil defense; much remains to be accomplished. It is an undertaking of the utmost importance, with many ramifications and problems, but it is one that must be solved. Not the least of these problems is one that confronts the medical profession in providing emergency medical service.

In an effort to provide a solution, the American Medical Association quite some time ago established a council known as National Emergency Medical Service. This council has been studying, evaluating, and assisting in coordinating the plans of local groups directed toward providing medical service for the civilian population in an emergency that may result from an attack on the United States.

In 1947, when I presented a paper before a General Session of the American Veterinary Medical Association, attention was directed to the responsibility of the veterinary profession in any future mobilization for war; also, that plans should be made and coordinated by the various interested divisions of the veterinary profession through a committee of the American Veterinary Medical Association, that the time to plan was before not after the blow was struck. I am more convinced now that any attack directed against the United States will be such that the veterinary profession will find its services not only required but demanded. Is civilian veterinary medicine prepared to

VETERINARY SERVICE

meet an emergency that might threaten the national welfare and security of this country? What studies have been made by organized veterinary medicine to ascertain to what extent the veterinary profession should participate in civil defense involving local, regional, state, and national planning.

It is realized that the large cities will most likely be the primary targets in any atomic attack on the United States. Granted such will be the case, you may well ask what need exists for veterinary service in civil defense plans. In such cases, however, stockyards, slaughterhouses, cold storage warehouses, and other storehouses of animal foods may well be within the target area and suffer damage. It is reasonable to assume that veterinary service will be required not only to treat injured animals but to determine which animals should be slaughtered and those that could be used for food. The services of veterinarians engaged in public health work, including food inspection and sanitation, will be required to render decisions relative to the salvage and safety of food for human consumption. Veterinarians surplus to such needs will no doubt be utilized in aiding public health officers in preventive medicine and disease control work among the civilian population.

A bomb dropped over a large city and exploding will cause numerous casualties resulting in the medical service being taxed to the utmost in providing emergency care, evacuation, and treatment. Physicians undoubtedly will require considerable help in caring for the injured. It is possible there will be a number of veterinarians, particularly small animal practitioners, available who could render considerable service to the medical service in such a disaster. I do not know whether the medical profession has thought of this reservoir. They should.

The smaller cities and towns are not likely to be primary targets. However, with the development of long-range, fast-flying planes capable of carrying small but powerful bombs or other destructive material, such places might well be subject to attack. The cities and towns adjacent to a large city should be organized for civil defense not only for their own protection but to render assistance to a neighboring city. Such assistance will be needed, and I include veterinary service.

We have talked about atom bombs and cities. As a result, those veterinarians who do general practice in the country no doubt feel left out of the picture. If you have such a thought, dispel it. My next point should convince you why the entire civilian veterinary profession must be organized to participate in civil defense.

Earlier I mentioned we must be prepared for unconventional forms of attack. Publicity has already been given to the idea that one of these could be attempted against the livestock population directly in the form of biological warfare, with devastating results - yes, even to retard waging a successful war, to say nothing of the economic impact. I do not want to infer that such a method of warfare will be used by any country. It is, however, foolish to deny that it could be undertaken as a weapon of war. It is an axiom of war that a good commander is never taken by surprise.

This speech was presented 14 June 1950, The Annual Conference for Veterinarians, Ohio State University, Columbus, Ohio.

* * * * *

GOOD NEIGHBOR POLICY

In evaluating the health of the command, equal consideration must be given to the civilian community adjacent to the military station, the civilian population living within the station and the military personnel. Almost always the health experiences of the military command parallel those of the civilian community. Frequently, the local military preventive medicine officer can anticipate health trends within his command by following closely the health experiences within the nearby civilian communities. In order to do this, a close liaison with municipal and State health agencies is necessary. We have long recognized that the civilian community has constituted the reservoir of venereal infection for the soldier. It is equally true that the civilian community is a reservoir for other infectious diseases. The answer to the question: "How are we going to empty this civilian reservoir of disease," depends on how firmly the liaison between military preventive medicine and civilian public health practices has been established. The command surgeon, the post medical inspector, and the post sanitary inspector can do much toward establishing this liaison by working with his opposite number in the civilian agency.

ADMINISTRATIVE SERVICE

MILITARY ASSISTANCE

Reproduced below are answers of the Military District of Washington Staff Judge Advocate, in answer to specific questions regarding Medical Officer's liability in the treatment of civilian casualties:

a. In the case of a suit against a doctor, as an individual, arising out of treatment rendered by performance of his duty in a disaster, will your section provide legal assistance for the doctor, as an individual, and furnish him with necessary counsel for the defense of this suit?

Answer: Yes

b. Can such suit be brought directly into the jurisdiction of the Federal Courts if the treatment is given in one of the surrounding States bordering on the District of Columbia?

Answer: Yes

c. If the answer to "b" above is in the negative, resulting in the State Courts having jurisdiction over the parties and subject matters of the suit, will your section furnish necessary counsel for the defense of this suit?

Answer: Yes

d. If the answer to "b" above is in the affirmative and the Federal Courts have jurisdiction over the parties and subject matters, will your section furnish necessary counsel for the defense of this suit?

Answer: Yes

e. If the party bringing suit against the doctor, as an individual, is successful, what type of monetary reimbursement facilities are available for the doctor to pursue by virtue of his acting as an agent of the Federal Government on competent orders at the time the treatment was given?

Answer: I want to point out to you one thing, however. Where an officer or soldier is sued for damages for an act done under color of his office and judgment is obtained against him notwithstanding all the legal assistance the Attorney General and The Judge Advocate General are able to give him, there is no law which will relieve him from the judgment. The only way he can get relief is to apply to the Congress for a private act granting him relief by appropriating the necessary money to pay the judgment. He can get relief from the cost of the suit as the statutes provide that the cost may be taxed against the Government.

f. If a military doctor responding to orders issued during a disaster gives treatment to a civilian in a State or District in which he is not licensed to practice medicine, is he liable in a suit by the State or District for practicing without a license? If such suit arose would your section furnish defense for the doctor, as an individual?

Answer: Not liable. Counsel would be furnished.

Under Article of War 117 and Section 1442 of Title 28, U. S. Code, when any civil or criminal prosecution is commenced in any court of a state of the United States against any officer, soldier or other person in the military service of the United States or any civil officer of the United States on account of any act done under color of his office, such suit or prosecution may, at any time before the trial or final hearing thereof, be removed for trial into the District Court of the United States in the District where the same is pending and the cause thereupon be entered on the docket of such District Court which shall proceed as if the cause had originally been commenced in such Federal District Court.

The Attorney General of the United States in Circular Number 4122, dated 11 May 1950, directed all District Attorneys to furnish legal counsel for all officers and agents of the United States Government who are sued or prosecuted because of acts done under color of their office. The usual procedure in the case of a member of the military service is to report the fact of the suit or

ADMINISTRATIVE SERVICE

prosecution to the Staff Judge Advocate of his organization. In the case of the Military District of Washington the report should be made to me. Upon receipt of this information I will call on the Litigation Division of The Adjutant General's Corps to furnish counsel and that division in cooperation with the Attorney General will see to it that the officer or soldier is properly represented.

* * * * *

CHECK LIST FOR LIVING

AWAY FROM HOME

If caught in the open: lie down against a building, in a ditch or gutter. Cover yourself with newspaper, cloth and discard it without touching it any more than possible after the blast. Cover your eyes with your arm, and keep them covered for at least 10 seconds after the blast.

With warning: get into a shelter, the basement of a building, or at least against an interior partition. Cover your eyes.

Wait for guidance by Civil Defense authorities to be set up before you try to get out of the area.

AT HOME

Before an attack is imminent, establish a "bomb area," preferably in your basement, with emergency equipment available. This should include: at least one flashlight with replacement batteries; a day's supply of food (canned tomatoes, water-packed fruits are simplest, providing both nourishment and liquids); an axe or hatchet for use in the event the blast seals off exits. Water, in covered containers, is also advisable.

At the first alert, shut off all utilities where they enter the house: gas, electricity, oil burners. Shut all doors, windows, chimney vents. Close all shutters or venetian blinds. As soon as this is done, keep all occupants of the home in the "bomb area" until after the all clear has been sounded. Have them lie against the basement walls for greatest protection, preferably near major supports. Wear light, loose clothes.

Food left upstairs may be used after an attack unless it was lying uncovered in the open. Do not use the water supply until you have been told it is safe by city authorities, or if you have to use it, boil it. Turn your radio on, it will not be affected, and it will be used by authorities for instructions. Television sets will not be affected. Do not try to use the telephone except in emergencies --- the facilities will be needed for urgent calls. Do not turn on gas, oil or electricity until checked for damage.

GENERAL

Do not attempt a panic-stricken flight. Highways could turn into death traps. If you're prepared, you are safe at home. Remember holiday traffic jams and think how far you could get in a fear-ridden mob (and there will always be a frightened few). Do have a general knowledge of surrounding geography for extreme emergency use, remembering always that the mob will use the main routes. Know the back roads.

Establish within your family an emergency rendezvous outside the home area. Circumstances could make it necessary that a family separated under attack have some one place within a reasonable distance where all could check in.

If fire or other hazards force evacuation, don't try to carry too much. One change of clothing is a good rule of thumb. It might be a long walk. Wear heavy duty clothes.

Fear is an unreasonable thing. Avoid it. Be ready and be calm.

(The above article is from "PEGASUS" Vol. 16, August 1950, No. 2, pages 2 and 3).

PREVENTIVE MEDICINE

RESTRICTED

GENERAL COMMENT

The health of the command continued to be excellent.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and Class II installations exclusive of Walter Reed Army Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army Medical Service installations do not include Air Force personnel. (See General Data and Admissions Tables on page 14).

The non-effective rate* increased from the October rate of 13.91 to 15.20 for the month of November. Days lost as a result of disease and injury totaled 8,717 during the four week period ending 24 November 1950.

$$\text{*Non-Effective Rate} = \frac{\text{Total Days lost} \times 1,000}{\text{No. of Days in Period} \times \text{Average Daily Strength}}$$

Non-effective rates indicate the average number of patients in hospital or quarters per thousand mean strength during the report period.

The total admission rate** for disease and injury in November was 534.8, compared to 445.9 during October. Total admission for disease and injury in November was 942. Of this number, 852 admissions were for disease and 90 injuries. Fort Myer reported the highest admission rate, and US Army Dispensary, The Pentagon reported the lowest rate during the current month.

$$\text{**Admission Rates} = \frac{1,000 \times 365 \times \text{Number of Cases}}{\text{Mean Strength} \times \text{No. of Days in Period}}$$

Admission rates show the number of cases per thousand strength that would occur during a year if cases occurred throughout the year at the same rate as in the report period.

November's rate for disease cases is 483.7 for 852 cases. Fort Myer reported the highest admission rate, and US Army Dispensary, The Pentagon, reported the lowest rate for disease cases.

An injury admission rate of 51.1 per 1,000 per annum for November was reported. This was an increase from the October rate of 34.6. Fort Myer reported the highest rate and US Army Dispensary, The Pentagon reported the lowest rate for injuries.

There were 5 deaths reported during the four-week period ending 24 November 1950, by units within the Military District of Washington less Walter Reed Army Hospital.

COMMUNICABLE DISEASE

Common respiratory diseases increased in incidence during the month of November, 1950. The rate for the present month is 149.3 compared to the October rate of 119.5. Fort Belvoir reported the highest rate, and Fort McNair, reported the lowest rate. Admission rates for pneumonia (all types) increased during the November report period. The rate being 14.7 compared with the October rate of 4.9. There were no cases of scarlet fever reported throughout the month of November.

No appreciable change was noted in the rate for mumps, tuberculosis, rheumatic fever, diarrheal disease, and hepatitis during the four week period ending 24 November 1950.

Pertinent statistical tables may be found on pages 15 and 19.

RESTRICTED

PREVENTIVE MEDICINE

RESTRICTED

GENERAL DATA
4-Week Period Ending 24 November 1950
(Data from WD AGO Forms 8-122)

STATION	MEAN STRENGTH			DIRECT ADMISSIONS						Non-Effective Rate	Number of Deaths
	Total	White	Negro	All Causes		Disease		Injuries			
				Cases	Rates	Cases	Rates	Cases	Rates		
Fort Belvoir, Virginia	13074	11614	1460	609	607.18	545	543.37	64	63.81	17.59	5
Fort McNair, Wash., D.C.	799	733	66	15	244.71	12	195.77	3	48.94	7.24	0
Fort Myer, Virginia	1872	1696	176	140	974.84	128	83.56	12	83.56	20.91	0
So. Post, Fort Myer, Va.	1956	1944	12	91	606.43	85	566.45	6	39.98	13.55	0
US Army Dispensary, The Pentagon	3506	3486	20	53	197.05	50	185.90	3	11.15	11.17	0
All Others	1750	1748	2	34	253.25	32	238.35	2	14.90	4.82	0
Total - Military District of Washington	22957	21221	1736	942	534.87	852	483.77	90	51.10	15.20	5
AMC - Med Det (Duty Pers)	1400	1311	89	57	530.10	54	502.70	3	27.40	5.80	0

ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR
4-Week Period Ending 24 November 1950
(Data from WD AGO Forms 8-122)

STATION	Common Respiratory Disease	Pneumonia All Types	Pneumonia Atypical	Influenza	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Diar-rheal Disease	Hepatitis	Malaria	Psychiatric Disease
Fort Belvoir, Virginia	196.41	21.93	5.98	-	34.90	-	-	-	1.00	1.00	1.00	-	12.96
Fort McNair, Wash., D.C.	48.94	-	-	-	-	-	-	-	-	32.63	-	-	-
Fort Myer, Virginia	160.15	6.96	-	34.82	-	-	-	-	-	6.96	-	-	-
So. Post, Fort Myer, Va.	166.60	6.66	6.66	-	-	-	-	-	-	-	-	-	-
US Army Dispensary, The Pentagon	55.77	7.43	7.43	14.87	3.72	-	-	-	-	-	-	-	11.15
All Others	-	-	-	-	-	-	-	-	-	-	-	-	-
Total - Military District of Washington	149.33	14.76	5.11	5.11	20.44	-	-	-	.57	2.27	.57	-	9.08
AMC - Med Det (Duty Pers)	9.10	9.10	-	-	-	-	-	-	-	-	9.10	-	-

* * *
"One should not underestimate, even though its exact status will never be known, the function of the mental state in the establishment and maintenance of health". Charles Mayo

* * *
"Scientific medicine, being founded on demonstrable truths, must in the end maintain itself and secure the confidence of the people". General Sternber - Address to AMA 1898

RESTRICTED

PREVENTIVE MEDICINE

RESTRICTED

VENEREAL DISEASE

Venereal Disease rate among units within the Military District of Washington, increased during the November report period.

The rate for November 1950, was 14.76 increasing over the October rate of 10.53. A total of 26 cases were reported for the four week period ending 24 November 1950. Of this total 23 were reported by Fort Belvoir, 2 for South Post, Fort Myer, and 1 for All Others.

During the report period, white personnel incurred 17 of the reported number of cases, with a rate of 10.44 and 9 were incurred by negro personnel, with a resulting rate of 67.58 per 1000 troops per annum.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designated station, we have undertaken to report the number of cases per 1000 men for this report period (November) in addition to the rate per 1000 per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 17, 18 and 19.

NEW VENEREAL DISEASE CASES - EXCL EPTS - SEPTEMBER, OCTOBER AND NOVEMBER 1950

STATION	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 1000 Troops
	SEPTEMBER 50	OCTOBER 50	NOVEMBER 50	NOVEMBER 50
Fort Belvoir	39.36	16.06	22.93	1.76
Fort McNair	-	-	-	--
Fort Myer	7.50	-	-	-
South Post, Fort Myer	-	7.64	13.33	1.02
U.S. Army Dispensary, Pentagon	2.90	-	-	-
All Others	-	14.24	7.45	.57
Total - Military District of Washington Units	19.94	10.53	14.76	1.13
Army Medical Center - Medical and Holding Detachments	-	4.66	-	-
Total - Dept/Army Units Mil Dist of Washington	17.32	9.84	13.11	1.01
	* * * * *	* * * * *	* * * * *	

"It is the soldier's duty to maintain the post he is ordered to defend. The same climate and season that affect us affect our enemies, and the favor of the Almighty, to whom we have appealed will, if we trust in him, preserve us from slavery and death". General Gates, August 21, 1776.

* * * * *

"The man who graduates today and stops learning tomorrow is uneducated the day after".

Newton D. Baker

RESTRICTED

RESTRICTED

PREVENTIVE MEDICINE

CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY
MDW RATE PER 1000 TROOPS PER YEAR

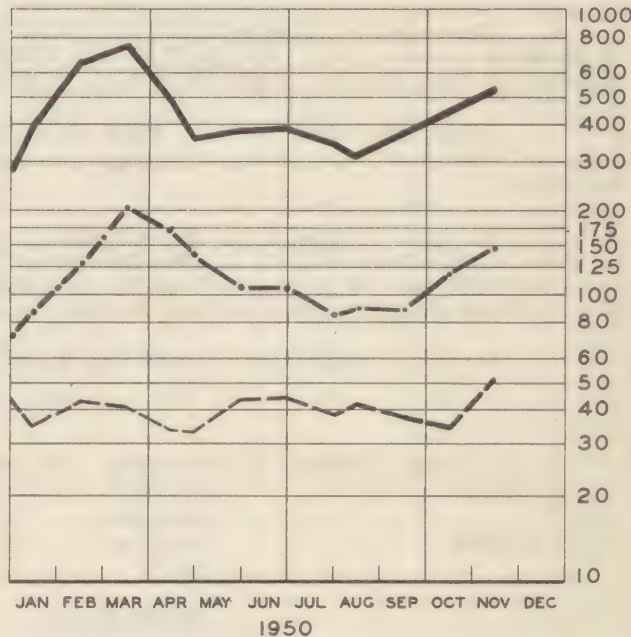
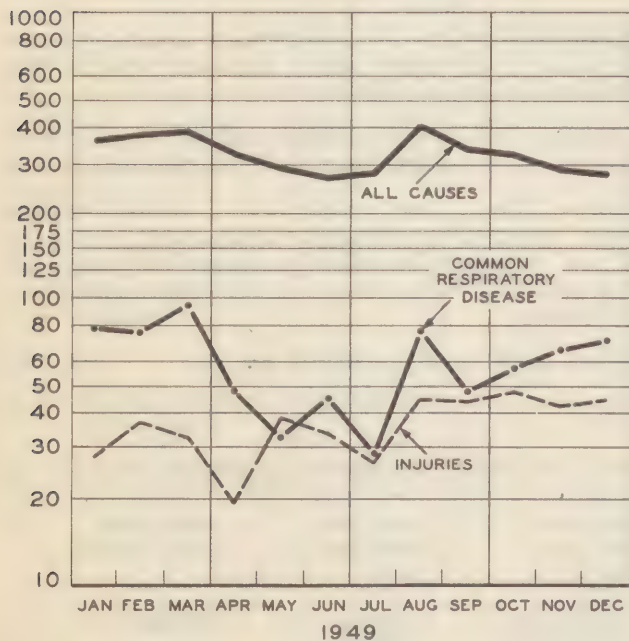
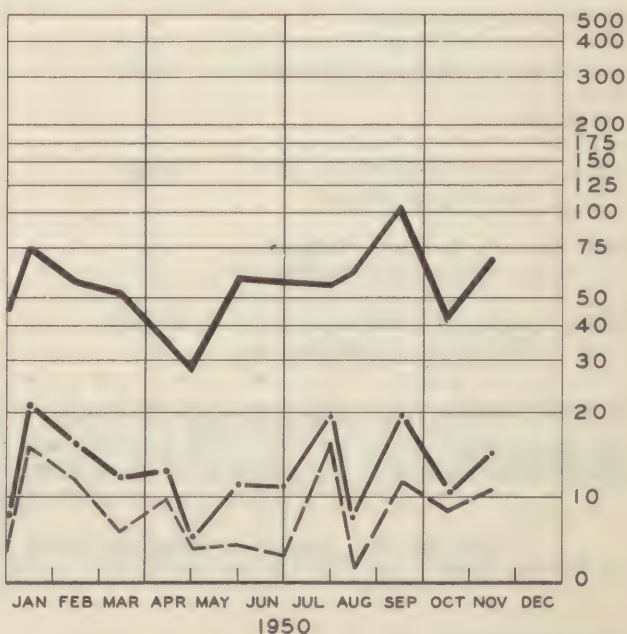
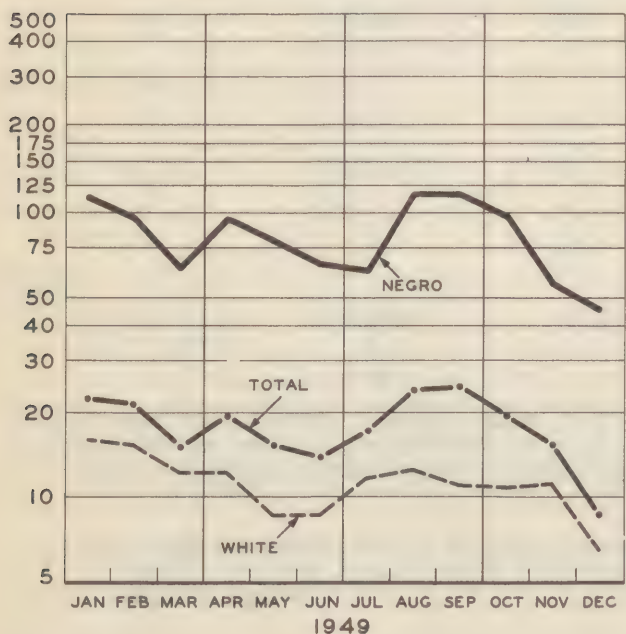


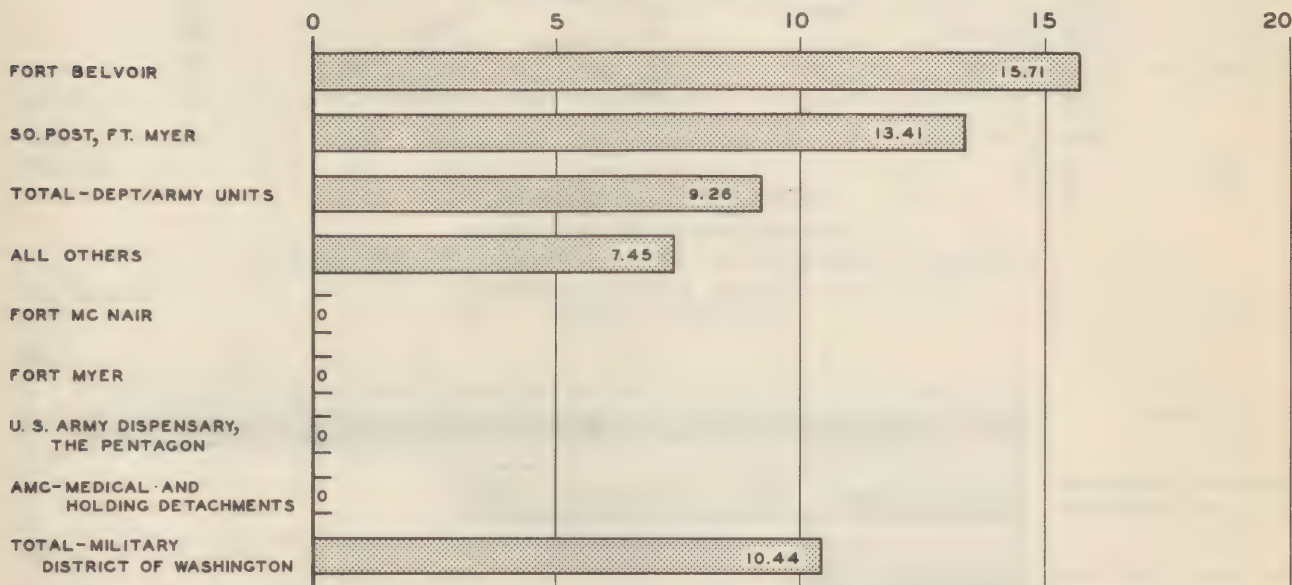
CHART 2

ADMISSION RATES BY MONTH VENEREAL DISEASES MDW NOT INCL. ARMY MEDICAL CENTER
RATES PER 1000 TROOPS PER YEAR
INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS

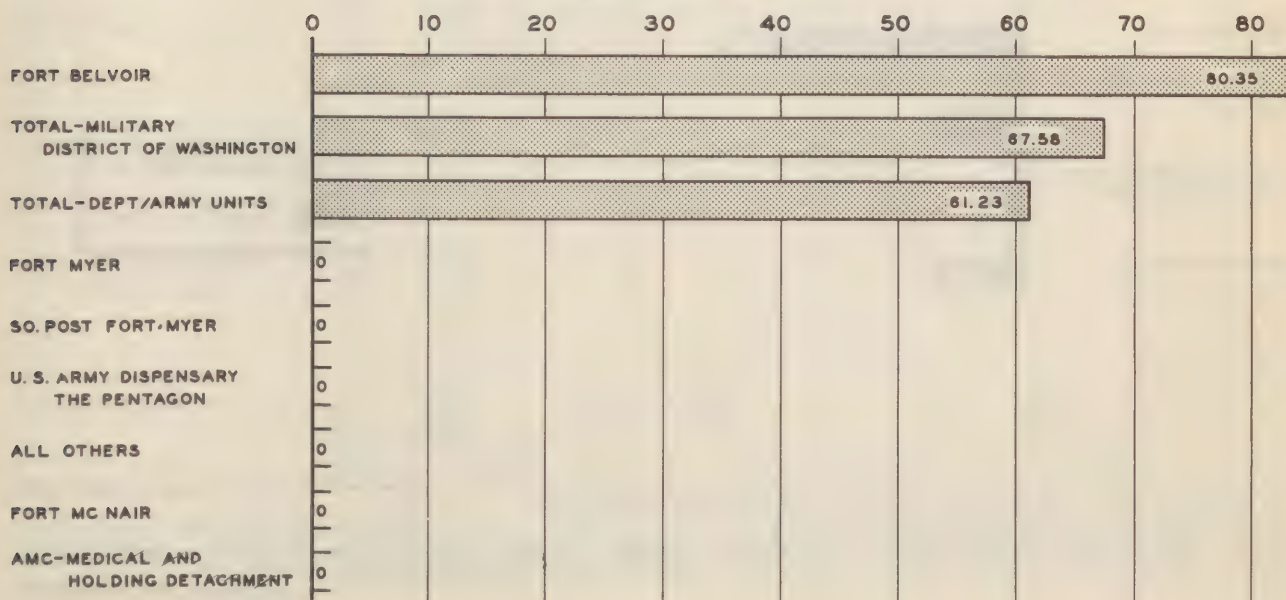


RESTRICTED

VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 4 WEEK PERIOD ENDING 24 NOV 1950 WHITE PERSONNEL (CHARGEABLE CASES)



VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 4 WEEK PERIOD ENDING 24 NOV 1950 NEGRO PERSONNEL (CHARGEABLE CASES)



PREVENTIVE MEDICINE

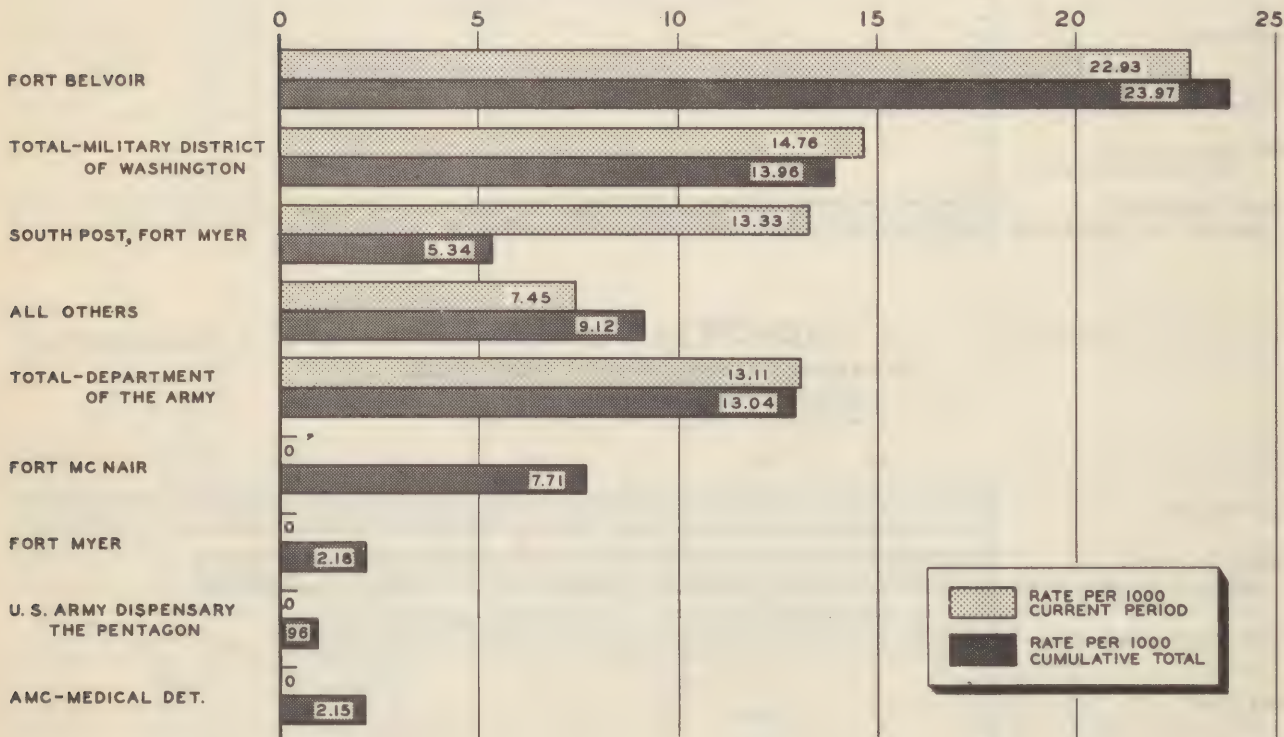
RESTRICTED

VENEREAL DISEASE RATES FOR US*

(ALL Army Troops)

	SEPTEMBER 1950	OCTOBER 1950	NOVEMBER 1950
First Army Area	21	14	14
Second Army Area	25	25	17
Military District of Washington	17	10	13
Third Army Area	24	23	24
Fourth Army Area	18	17	22
Fifth Army Area	11	14	13
Sixth Army Area	34	18	15
TOTAL United States	22	19	17

VENEREAL DISEASE RATES PER 1000 PER YEAR 4 WEEK & CUMULATIVE TOTALS ENDING 24 NOV 1950 TOTAL WHITE & NEGRO PERSONNEL (CHARGEABLE CASES)



SANITARY ORDER

Thou shalt have a place also without the camp, whither thou shalt go forth abroad:

And thou shalt have a paddle upon thy weapon; and it shall be, when thou wilt ease thyself abroad, thou shalt dig therewith, and shalt turn back and cover that which cometh from thee:

For the LORD thy God walketh in the midst of thy camp, to deliver thee, and to give up thine enemies before thee; therefore shall thy camp be holy; that he see no unclean thing in thee, and turn away from thee.--

Deuteronomy, 23: 12-14

RESTRICTED

PREVENTIVE MEDICINE

RESTRICTED

CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT For the Four Week Period Ending 24 November 1950 (Data from WD AGO 8-122) (Chargeable Cases)

STATION	R A C E	Mean Strength	Number of Cases-EPTS Not Included				Rate per 1000 Troops Per Annum	Total Days Lost From Duty (Old & New Cases)
			Syphilis	Gonorrhea	Other	Total		
Fort Belvoir	W	11,614	2	12	0	14	15.71	4
	N	1,460	1	8	0	9	80.35	11
	T	13,074	3	20	0	23	22.93	15
Fort McNair	W	733	0	0	0	0	-	0
	N	66	0	0	0	0	-	0
	T	799	0	0	0	0	-	0
Fort Myer	W	1,696	0	0	0	0	-	0
	N	176	0	0	0	0	-	0
	T	1,872	0	0	0	0	-	0
South Post, Ft Myer	W	1,944	1	1	0	2	13.41	0
	N	12	0	0	0	0	-	0
	T	1,956	1	1	0	2	13.33	0
US Army Dispensary, The Pentagon	W	3,486	0	0	0	0	-	0
	N	20	0	0	0	0	-	0
	T	3,506	0	0	0	0	-	0
All Other	W	1,748	0	1	0	1	7.45	0
	N	2	0	0	0	0	-	0
	T	1,750	0	1	0	1	7.45	0
Total - Military Dis- trict of Washington	W	21,221	3	14	0	17	10.44	4
	N	1,736	1	8	0	9	67.58	11
	T	22,957	4	22	0	26	14.76	15
Army Medical Center - Med. & Hold. Det.	W	2,711	0	0	0	0	-	0
	N	180	0	0	0	0	-	0
	T	2,891	0	0	0	0	-	0
Total Dept/Army Units	W	23,932	3	14	0	17	9.26	4
	N	1,916	1	8	0	9	61.23	11
	T	25,848	4	22	0	26	13.11	15

Correction: The Total Department of the Army Consolidated Monthly Venereal Disease, reported in the November issue as White: 30.73, Negro: 146.39, Total: 39.36, should read White: 7.68, Negro: 36.59, Total: 9.84.

RESTRICTED

DENTAL SERVICE

RESTRICTED

DENTAL SERVICE - FOUR WEEK PERIOD ENDING 24 NOVEMBER 1950

STATION	Military		Civilian		Sit- tings	Amal- gam	Oxy and Amal	Sili- cate	In- lays	Bridges	Bridge Repair	Crowns	Dentures			Extrac- tions	Calcu- lus Removed	X-Rays	Exami- nations
	Men	Duty Days	Men	Duty Days									Full	Par- tial	Re- pair				
Fort Belvoir	10	294	1	22	3414	433	652	202	3	16	9	8	12	15	24	706	194	849	1126
Fort McNair	2	60	0	0	327	155	118	60	0	1	0	1	0	3	2	42	20	90	77
Fort Myer, Va.	3	87	0	0	1155	372	38	74	1	3	2	2	6	19	4	116	13	945	257
So Post, Ft Myer	1	15	1	20	340	119	84	17	0	0	0	0	2	2	4	34	16	67	70
US Army, Dispen- sary, Pentagon	6	172	0	0	2287	371	179	118	0	3	10	0	12	15	26	110	244	615	591
All Others	2	57	0	0	302	170	58	46	1	0	0	0	2	8	1	58	35	65	178
Total - MDW	24	685	2	42	7825	1620	1129	517	5	23	21	11	34	62	61	1066	522	2531	2299

VETERINARY SERVICE

POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED NOVEMBER 1950
(Data obtained from WD AGO Forms 8-134)

STATION	CLASS * 3	CLASS * 4	CLASS * 5	CLASS * 6	CLASS * 7	CLASS * 8	CLASS * 9	TOTAL
Fort Lesley J. McNair		65,279	129,226		182,817		71,692	449,014
Fort Belvoir, Virginia		458,224	412,311		1,080,456	121,211	518,561	2,590,763
Alexandria Field Buying Office		486,049	100,789	635,197			52,499	1,274,534
Fort Myer, Virginia		225,335	275,069		424,913	7,090	145,357	1,077,764
Cameron Station, Virginia		181,648	172,203	59	356,920	5,310	100,980	817,120
Military District of Washington								
Veterinary Detachment	411,181							411,181
The Pentagon,						286,709		286,709
TOTALS	411,181	1,416,535	1,089,598	635,256	2,045,106	420,320	889,089	6,907,085
REJECTIONS:								
Insanitary or Unsound								
Alex. Field Buying Office		7,200						7,200
Fort Myer, Virginia					11,986			11,986
Mil Dist/Wash Vet Det.	390							390
Fort McNair					88			88
Not type, class or grade								
Alex. Field Buying Office		4,942						4,942
Cameron Station, Va.		21						21
Mil Dist/Wash Vet Det.	35,253							35,253
TOTAL REJECTIONS	35,643	12,163			12,074			59,880

*Class 3 - Prior to Purchase

*Class 4 - On delivery at Purchase

*Class 5 - Army Receipt except Purchase

*Class 6 - Prior to Shipment

*Class 7 - At Issue

*Class 8 - Purchase by Post Exchange, Clubs,
Messes or Post Restaurants

*Class 9 - Storage

OUTPATIENT SERVICE.

OUTPATIENT SERVICE

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed Army Hospital, are indicated below for the four - week period ending 24 November 1950:

ARMY:

Number of Outpatients 5330

Number of Treatments 20700

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED 927

NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED 7586

NON-ARMY:

Number of Outpatients 7138

Number of Treatments 19021

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED 927

NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED 7586

HOSPITAL MESS ADMINISTRATION

HOSPITAL MESS ADMINISTRATION

STATION	AUGUST 1950	SEPTEMBER 1950	OCTOBER 1950	NOVEMBER 1950
Fort Belvoir				
Income per Ration	\$1.1074	\$1.1591	\$1.1625	\$1.1432
Expense per Ration	1.0177	.9019	.9538	.9105
Gain or Loss	+.0897	+.2572	+.2087	+.2327

RESTRICTED

DEPARTMENT OF DEFENSE

CIVILIAN EMPLOYEES HEALTH SERVICE PROGRAM

METROPOLITAN AREA OF WASHINGTON

THE NURSE IN THE CIVILIAN EMPLOYEE HEALTH SERVICE

Margaret H. Rumsey, R.N.
Chief Nurse, Pentagon Dispensary
Civilian Employees Health Service

The Nurse in the Civilian Employee Health Service Program becomes no longer just a "First Aider" - that is, some one who only provides first aid after an injury or gives a pill after an illness has occurred. Instead, she tries to prevent an illness and an injury from occurring and to assist the employee in keeping well and on-the-job.

The above objectives are accomplished only by close cooperation with personnel in the area she is serving and with the various health and welfare agencies in the community.

She is in a strategic position to observe various health factors which may be directly or indirectly affecting the health and efficiency of an individual. A good example is the employee with "frequent headaches" necessitating many dispensary visits with much lost job time. By tactful, efficient health guidance such an employee is placed under proper medical care and job adjustment is made.

The nurse cooperates closely with the employees' immediate supervisor in the event of sudden on the job illness. She assists the employee to the Dispensary where she arranges to have a staff physician to see the employee, arranges transportation if necessary and makes the referral to proper resources when further care is indicated.

The treatment of occupational injuries is the concern of the Dispensary nurse. The care to this class of cases is given in close cooperation with the staff physician who in turn refers the employee to the United States Public Health Service Clinic for any further care if other than routine emergency treatment is necessary. The nurse cooperates with the Safety Engineer in this phase of the work by immediately reporting any occupational hazard for investigation and correction to prevent similar accidents. She works hand in hand with personnel by immediately notifying them of the above, so that proper forms can be executed, thus assuring the employee his right to treatment and compensation.

The above incidents show in a very minute way the value and need of nurses in a Civilian Health Program and their value will continue to increase along with the expansion of the Program.

RESTRICTED

RESTRICTED